In the Matter of:	)	
	)	**Date Issued: March 29, 1999**
Madeline Hall,	)	
Claimant	)	**Case No. 1998-LHC-619**
	)	
v.	)	**OWCP No. 02-118941**
	)	
Autec Range Services,	)	
Employer	)	
	)	

APPEARANCES:

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For Claimant

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For Employer

BEFORE: C. Richard Avery
Administrative Law Judge

DECISION AND ORDER

This is a claim for benefits under the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 901 et seq., (The Act), brought by Madeline Hall against Autec Range Services. The formal hearing was conducted at Mobile, Alabama on September 18, 1998. Both parties were represented by counsel and each party presented documentary evidence, examined and cross-examined the witnesses, and made oral arguments. The following exhibits were received into

evidence: Joint Exhibit 1; Claimant's Exhibits 1-17; and Employer's Exhibits 1-39, 40A through 40G, and 41. This decision is based on the entire record.[1]

Stipulations

Prior to the submissions, the parties entered into joint stipulations of facts and issues as follows:

1. An accident/injury occurred on May 24, 1996;
2. An employer/employee relationship existed at the time of the injury;
3. The accident/injury occurred in the course and scope of employment;
4. Employer was notified of the injury on May 24, 1996;
5. A Notice of Controversion was filed on February 24, 1996;
6. An informal conference was held on July 16, 1997;
7. Claimant received temporary total disability payments of $220.80 per week from May 30, 1996, through October 26, 1996, and from November 26, 1996, through March 6, 1998.

Unresolved Issues[2]

The unresolved issues in this proceeding are:

1. Whether or not Claimant has reached maximum medical improvement;
2. Nature and extent of Claimant's injury;
3. Whether or not Claimant is entitled to continue medical treatment with an authorized physician in the geographic area in which she now resides;
4. Whether or not Employer is responsible for past and continuing medical benefits and travel expenses;
5. Whether Employer is entitled to a credit of $189.26 for payments made from October 21, 1996, through October 26, 1996;
6. Whether Employer is entitled to 8(f) relief.

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[1] The following abbreviations will be used throughout this decision when citing evidence of record: Trial Transcript Pages - "Tr. __, lines __"; Joint Exhibit - "JX __, pg. __"; Employer's Exhibit - "EX __, pg. ___"; and Claimant's Exhibit - "CX __, pg. ___".

[2] Although average weekly wage was listed as an issue at the time of the hearing, Claimant, in her post-hearing brief, withdrew the issue in light of the Ronald Guthrie Decision, 114 F.3d 120 (9th Cir. 1997). Therefore, the evidence of record establishes Claimant's average weekly wage at the time of injury was $331.20 a week.

Statement of the Case
Testimonial Evidence

Claimant, born August 11, 1951, grew up in Mobile, Alabama and obtained her GED in 1971. She worked as a waitress before attending a business college after which she obtained employment as a secretary and then as a department manager for Montgomery Ward. In 1990, Claimant became a munitions accountability expert employed by Raytheon and contracted with the Army.

On October 10, 1995, Claimant obtained employment with Autec, Employer in this case, after responding to an ad in the newspaper for a secretary to the public works manager. Claimant explained Employer performed underwater nuclear weapons testing for the Navy on Andros Island in the Bahamas. Claimant testified the job with Employer required her to live on the island in the Bahamas and perform a variety of tasks. While on the job Claimant was provided with food, transportation, and utilities in addition to her regular and foreign service pay.

In the course of her employment with Autec, Claimant was required to carry a shoulder bag of books and files which, according to Claimant, sometimes weighed over thirty pounds. Because Claimant's job assignments were diverse and sometimes involved multiple departments in one day, Claimant was required to walk all over the base carrying the shoulder bag. Just prior to her injury Claimant testified she bought a golf cart to avoid the extensive walking.

Years before this employment, Claimant testified she received an injury to her back when, at the age of 25, she ruptured a disc in a dune buggy incident and underwent surgery performed by Dr. Henry C. Mostellar, neurosurgeon. She testified that following the surgery she returned to work as a department manager for Montgomery Ward in a few weeks, but continued to experience occasional problems with her back. According to Claimant she received periodic treatment with Dr. Mostellar who performed a second surgery shortly thereafter on Claimant's lumbar spine. She last received treatment for her previous injuries in 1994, when she returned to Dr. Mostellar. Claimant testified that after recuperating from those surgeries she was able to perform a variety of physical activities including racquetball and received certification in scuba diving, operating a bulldozer, and a backhoe.

The injury in question occurred on May 24, 1996, when, after lunch, Claimant was standing with her shoulder bag waiting for her supervisor when she began to experience a burning and tearing sensation in her back. Claimant testified she left a note for her supervisor and was in extreme pain by the time she reached her room. Upon calling the dispensary she was informed the base doctor, Dr. Sweat, was out, but the nurse, Liz McCurdy**,** agreed to examine her. Ms. McCurdy administered Claimant a shot and a dose of pain medication on this initial examination, as well as several times over the weekend that followed.

Dr. Sweat eventually referred Claimant to Dr. Weltz in West Palm Beach, Florida. After initial testing, Dr. Weltz prescribed physical therapy which required Claimant to fly to the mainland three times a week. Claimant reported discomfort from the plane ride and the physical therapy and eventually had to end the treatment. The Employer then referred Claimant to Dr. Jordan G. Grabel, board certified neurosurgeon in West Palm Beach, Florida, who performed a fusion at C3-4 and C6-7 in July of 1996.

Claimant testified that during the surgery performed by Dr. Grabel, fluid entered Claimant's lung causing aspiration. After a brief stay in critical care, Claimant was allowed to return to the hotel where she was staying. According to Claimant, when she reached the hotel she began itching all over her body. Claimant denied experiencing any type of similar rash in the past and testified that the symptoms did not subside and that she has continued to experience itching on a daily basis.

Dr. Grabel released Claimant, and she returned to her home in Mobile, Alabama to recuperate. Upon returning home, Claimant testified she immediately begin breaking out in a rash which Dr. Grabel opined to be an allergic reaction to the pain medication. Claimant received treatment at the emergency room at Providence Hospital on four separate occasions and was provided a shot to treat the rash. After returning to Mobile, Claimant testified she also experienced continued numbness and pain down the back of her left arm and difficulty moving due to pain and discomfort in her cervical area. She was examined by Dr. Grabel again in May of 1997, and following the visit requested Dr. Grabel refer her to a physician closer to Mobile. Although Dr. Grabel issued a referral for Claimant to receive treatment by Dr. Robert White, the request was never approved by Employer.

Subsequently, Claimant's relatives referred her to Dr. William Fleet, a board certified neurosurgeon, with a practice in Alabama. He first examined Claimant in January of 1998. Claimant testified she needed a doctor because she needed relief from the pain. Dr. Fleet provided Claimant with a neck brace, samples of pain medication and recommended ice packs and heat for her neck pain. Claimant testified she continues to experience limited movement in her neck and described the pain in her neck and arm as constant. She has difficulty lifting anything with her left arm, difficulty sleeping due to the pain, frequent headaches, and outbreaks of urticaria. Claimant also testified that since the 1996 surgery she has experienced a sensation analogous to a stick in her throat.

According to Claimant's testimony, she underwent an independent medical examination (IME) at Employer's request with Dr. Elias Chalhub, board certified neurologist, in January of 1998. Claimant testified Dr. Chalhub was rude to her and only spent five minutes on his examination. Claimant also underwent a functional capacity evaluation and testified that the examiner frequently left the room during the testing and failed to return until several minutes after Claimant ended the task.

Claimant stated she has never been provided an opportunity to select a physician of her own choosing and would like a physician in the Mobile area. According to Claimant, some of Dr. Fleet's bills have still not been paid, and Claimant has not been reimbursed for travel expenses related to her medical treatment. Claimant testified she has prescriptions for Neurontin, Remeron, Doxepin, Amitriptyline, and Lodine.

Claimant attempted to return to work in the fall of 1996, in Employer's West Palm Beach office, three or four hours a day. However, Claimant testified that the pain became unbearable and after several days Claimant discontinued working. Claimant has not received any disability payments since March 6, 1998. Claimant received a job survey and testified she contacted every employer identified. The phone numbers for two employers were disconnected, and upon contacting the other employers, Claimant was informed there were no positions available. Only Bleachers had an available position and it was part-time and involved carrying trays of food.

Claimant stated she additionally searched for jobs herself in the newspaper and responded to seven listed positions by sending resumes. She applied for the

positions because she needed a job, but felt she was unable to perform the duties required because they involved remaining in one position for lengthy periods of time, which she described as painful. Claimant did not follow up on any of the applications.

Claimant testified she did not feel capable of working at the present time due to the constant pain and the side effects of the medication. Claimant stated she was unable to sit for more than six hours, stand for three or four hours, or walk for one to three hours at a time, without discomfort. Additionally, Claimant related her inability to hold things with her left hand. Claimant testified that her emotional condition was fragile due to her inability to have a job or a life. She stated that she had always worked until the accident and would be willing to see a psychiatrist or a psychologist but was unable to afford one on her own.

Claimant testified that she drives her car every couple of days and is capable of driving for several hours if she has to, but is forced to turn her entire upper body before making a turn to check for oncoming traffic. Although Claimant acknowledged that this was probably unsafe, because she was required to go to the grocery store, the post office and the doctor, she explained driving was a necessity. Additionally, Claimant noted it was the pain in her neck which prevented her from working and not the urticaria.

Claimant stated she earned $6.90 an hour while working for Employer, including her foreign service pay and agreed she was paid $331.20 a week on average, which did not include overtime and bonus pay. Claimant reported working about 20 hours of overtime in the seven months she was employed with Employer and explained the bonus was in lieu of a payraise and equaled about $800 made in two equal payments. Employer provided Claimant with three meals a day, every day, from the base cafeteria as well as base housing, both at no cost to Claimant. Claimant did not claim either the housing or the meals as income on her 1995 or 1996 tax returns.

Mr. Loyd Garner worked for Employer at the same time as Claimant as a heavy equipment mechanic in the transportation department. He testified that Claimant was an active person prior to her injury and he would see her walking all over base, fishing, and sightseeing. Mr. Garner testified he observed Claimant carrying a large bag full of books over her shoulder while working and observed

Claimant operating a bulldozer. After the accident, Mr. Garner visited Claimant on the island, at West Palm Beach, and at her home in Alabama. He testified that following the accident Claimant could hardly move her neck and could not stay in one position for any extended period of time. Mr. Garner has noticed no improvement in Claimant's condition since the accident, but has only seen her three or four times in the last 15 months. Mr. Garner has ridden in a car with Claimant once and described Claimant as "rigid" while driving. Mr. Garner opined there would be a good chance of an accident if Claimant drove in heavy traffic.

Kelly Evans, Claimant's daughter, testified that prior to Claimant's injury Claimant was very active and participated in activities such as scuba diving and mini marathons. Ms. Evans testified that since the accident Claimant has not improved and that she attempts to aid Claimant with routine household chores which Claimant finds difficult. Ms. Evans stated Claimant's emotional condition has grown more fragile since the accident. According to Ms. Evans, Claimant has expressed her desire to return to work if she was able.

Ms. Mary Lee testified she has worked for Raytheon at Employer's site on Andros Island since April of 1997, as a human resource administrator. According to Ms. Lee, Raytheon is the maintenance and operational contractor for Employer. Prior to her employment with Raytheon, Ms. Lee spent four years as the human resource administrator for Employer. While working for Employer her duties included interviewing, hiring, and processing employees, dealing with employee benefits, and she functioned as the workers' compensation administrator.

Ms. Lee testified Claimant was employed with Employer as the secretary for the base support manager, and as such her duties included work all over the base. Ms. Lee was aware Claimant carried a satchel over her shoulder while working and was aware of Claimant's injury. Ms. Lee stated Claimant earned $6.90 an hour and was required by contract to work 48 hour weeks. According to Ms. Lee, it was her job to contact the liaison in West Palm Beach to set up Claimant's initial medical evaluation. Ms. Lee testified Claimant did not request to see a physician other than Dr. Grabel.

Medical Evidence

Medical records from Dr. Henry C. Mostellar, neurosurgeon, are Employer's Exhibit 31, and reveal he last examined Claimant on April 2, 1993. Claimant

complained of occasional numbness in the left hand and examination revealed pain with hyperextension and lateral bending. Dr. Mostellar's impression was of cervical degenerative disc disease and mild left C-8 radiculopathy**.**

Employer's Exhibit 32 is the report of Dr. W. Dawson Durden, attending physician at the Queen Medical Center, in Honolulu, Hawaii, dated November 16, 1993. Claimant presented with complaints of severe abdominal pain, and Dr. Durden's impression was of possible mesenteric lymphadenitis. He planned to rule out cholecystitis and appendicitis and prescribed Demerol for Claimant's pain.

The medical records of Dr. Victor T. Bazzone, neurological surgeon, are Employer's Exhibit 33. On June 29, 1994, Claimant presented with pain in the neck, primarily on the left side, with pain radiating down into the left leg. Dr. Bazzone opined Claimant suffered from cervical and lumbar spondylosis and recommended Claimant undergo an MRI of the neck and low back.

An office note from Dr. Bazzone, dated July 18, 1994, stated Claimant's MRI was performed and revealed cervical and lumbar spondylosis. Dr. Bazzone opined surgery and further testing were unnecessary at that time. Claimant was provided with a prescription for Feldene and a follow-up examination was scheduled, however, Claimant failed to return. (EX 33).

Dr. Jordan G. Grabel, a board certified neurosurgeon, testified by deposition and his medical records are Claimant's Exhibit 7. Dr. Grabel first examined Claimant on July 8, 1996, with Claimant relating her May 24, 1996, accident. Examination revealed tenderness in the back of Claimant's neck and pain radiating into the shoulder blades upon flexion and lateral turning. Dr. Grabel stated he reviewed a June 1, 1996, MRI scan of the cervical spine, contained in Claimant's Exhibit 9, which disclosed a previous fusion at C5-6 and a disc protrusion at C3-4 and C6-7 with spondylosis or spurring. Dr. Grabel opined Claimant's complaints were consistent with Claimant's test results and that Claimant suffered from left cervical radicular syndrome which was not responding to conservative treatment. A myelogram was performed on July 12, 1996, revealing severe pathology at C3-4 with marked compression of the spinal cord on the left side, and multiple bone spurs, the most prominent at the C6-7 level. (CX 7, 9 & EX 1, 3).

Dr. Grabel recommended and performed surgery on July 31, 1996, in which he removed the C3-4 and C6-7discs replacing them with bone plugs. According to Claimant's Exhibit 8, Dr. David J. Stern, DO, provided a consultation when Claimant experienced an episode of wheezing following surgery. His plan was to exclude aspiration and his impression was of probable "white redman's syndrome" secondary to vancomycin. (CX 7 & 8).

Dr. Grabel next examined Claimant on August 9, 1996, for a follow-up visit, and then on September 20, 1996, with Claimant indicating neck stiffness, headaches, residual numbness in her left hand, and episodes of hives. Dr. Grabel noted Claimant was recuperating well following the surgery and recommended Claimant begin engaging in simple daily activities. (CX 7 & EX 4).

By October 4, 1996, Dr. Grabel agreed with Employer's plan to begin to reintegrate Claimant into her work environment by allowing Claimant to work up to four hours per day in Employer's West Palm Beach location. Claimant was next examined by Dr. Grabel on October 18, 1996, with a stable neurological exam and the surgical wounds well healed. Dr. Grabel issued a note on October 21, 1996, allowing Claimant to increase her workday to six hours per day. (CX 7 & EX 5-7).

According to Employer's Exhibit 20, Claimant was examined by Dr. Mark R. Stein, a board certified allergist, on October 15, 1996, with Claimant reporting improvement of her itching and rash symptoms upon taking her medication. Examination revealed a splotchy rash on Claimant's extremities, and Dr. Stein's impression was of chronic urticaria and chronic bronchitis secondary to cigarette smoking.

Claimant returned to Dr. Grabel on November 12, 1996, and Dr. Grabel noted steady improvement with Claimant's primary difficulty continuing to be her allergies. Claimants' neurological exam was stable, however, Claimant complained of heaviness in the left arm with increased activity. Dr. Grabel opined Claimant could return to her previous employment with a 15 pound lifting restriction. Claimant was also instructed to change positions frequently and to follow-up with the allergist, Dr. Stein, as needed.

Employer's Exhibits 21 through 28 are the medical records of Dr. Stephen F. Kemp, Assistant Professor of Medicine and Pediatrics, who treats allergy, asthma,

and immunology at the University of Alabama. The records reveal that Dr. Kemp examined Claimant on January 14, 1997, upon referral from Dr. Stein. Dr. Kemp was treating Claimant's chronic urticaria, bronchospasm, and sleep disorder with diffuse arthralgias and myalgias. Dr. Kemp agreed with Dr. Stein that Claimant's problems should not prevent her from working and noted Claimant's desire to return to work. Claimant returned to Dr. Kemp on January 28, 1997, with Claimant reporting three outbreaks of urticaria since her last visit and difficulty taking her medications as prescribed. Dr. Kemp opined Claimant's urticaria was clinically better and she was recommended to take her medications as prescribed. (EX 21 & 22).

On March 31, 1997, Claimant returned to Dr. Kemp with continued difficulty taking medications as prescribed. Dr. Kemp opined Claimant suffered from gastroesophageal reflux disease and changed her medications. An April 23, 1997, letter from Dr. Kemp to Employer's carrier stated that only the complaint of sleep disorder with diffuse arthralgias and myalgias appears to be related to Claimant's May, 1996, injury according to Claimant's history, but Dr. Kemp could not establish direct causation. Again, Dr. Kemp agreed with Dr. Stein's assessment that Claimant should be able to return to work in some capacity. (EX 23 & 24).

Claimant returned to Dr. Kemp on April 28, 1997, with Claimant complaining of hives two to three times a week and a particularly severe episode the night before her visit which interfered with her sleep. Claimant continued to complain of an abnormal sensation in her throat despite the medications provided and a recent upper respiratory infection. Medication was prescribed and Claimant was scheduled for a return visit within three months. (EX 25).

Dr. Grabel next examined Claimant on May 30, 1997, and the examination was normal except for subjective numbness of the left hand. Claimant related continued stiffness in her neck but less pain than upon her last visit. At this point, Dr. Grabel placed Claimant at maximum medical improvement and did not opine any further surgery or physical therapy to be necessary. (CX 7 & EX 8)

Dr. Grabel responded to a letter from Employer's carrier on June 4, 1997, in which Dr. Grabel did not recommend Claimant return to her secretarial position in the Bahamas because, due to her continued allergic response, she was in need of access to medical facilities. The Carrier again requested Dr. Grabel's release for

Claimant to return to her position in a non-remote area. Dr. Grabel responded on July 14, 1997, and opined Claimant was capable of working as a secretary and should undergo a functional capacity evaluation in order to determine specific work restrictions.

Dr. Kemp again examined Claimant on July 2, 1997, reporting daily hives over the last couple of weeks. Dr. Kemp conducted fiberoptic rhinoscopy to investigate Claimant's persistent complaint of something in her throat and the test revealed normal nasal and sinus passages with a narrowing of her hypopharynx. Dr. Kemp recommended a second opinion by Dr. Richard deShazo, Assistant Professor of Medicine in the Allergy Division at the University of South Alabama, in order to determine if the continued treatment plan should be altered. (EX 27).

Dr. deShazo evaluated Claimant on July 9, 1997, and he recommended continued medication for her urticaria and could identify no underlying disease in explanation of the condition. Dr. deShazo recommended an ENT evaluation due to Claimant's consistent complaints of laryngeal spasm and dysphagia and recommended Claimant undergo a rehabilitation program as soon as possible. (EX 29).

In a July 22, 1997, letter from Dr. Kemp to Employer's carrier, he again opined Claimant's immunologic problems would not keep Claimant from working, even in a remote location, as long as she was not exposed to irritants which would be likely to exacerbate her condition. Dr. Kemp also recommended Claimant be evaluated by an otolaryngologist for possible damage to her vocal chords. (EX 27 & 28).

According to Employer's Exhibit 16, Claimant underwent a functional capacity evaluation at Healthsouth Sports Medicine and Rehabilitation Clinic performed by Elizabeth A. Johnston, Industrial Rehabilitation Coordinator, and Bob Fleming, Physical Therapist, on August 28, 1997. Testing revealed consistent effort and lifting ability in the range of light duty work. Claimant was recommended to work in a light duty position.

Upon reviewing the FCE, Dr. Grabel authored a return to work notice on September 9, 1997, and signed the FCE on October 3, 1997, agreeing Claimant could return to work with the restrictions outlined in the FCE, which is Employer's

Exhibit 16. However, at his deposition Dr. Grabel acknowledged he would be more comfortable with an FCE performed by a physician rather than by an industrial rehabilitation coordinator or physical therapist, especially in a complicated case such as this one. (CX 7 & EX 9-12, 16)

According to Employer's Exhibit 30, Dr. Donald J. Muller, an ENT, performed an independent medical evaluation of Claimant, upon Employer's request, on December 18, 1997. Claimant's primary complaint was of a sensation of feeling like a "stick" was in her throat and Claimant related the onset of her complaint as her May, 1996, injury. An esophagram was recommended, and Dr. deShazo's impression was of probable functional cricopharyngeus spasm, sliding hiatal hernia without reflux, and chronic idiopathic urticaria. Dr. deShazo opined Claimant's current throat symptoms did not relate to Claimant's May, 1996, incident, but he speculated it could be related to scar tissue or neuropathy inherent in the anterior cervical discectomy approach undertaken during Claimant's July, 1996, surgical procedure. (EX 30).

Dr. Elias Chalhub, a board certified neurologist, testified by deposition that he first examined Claimant on January 7, 1998, and his reports are Employer's Exhibits 13-15. Upon examination, Claimant related her May, 1996, injury followed by a cervical diskectomy. Claimant's physical examination was normal, but Claimant complained of pain in her neck and left shoulder and numbness in the left hand. EMG and nerve conduction studies were also normal. Dr. Chalhub opined Claimant could return to work with a twenty-five pound weight limit. In an April 1, 1998, letter, Dr. Chalhub stated Claimant should have further neurological care in order to manage her pain. Dr. Chalhub testified Claimant suffers from cervical degenerative disease which he opined had nothing to do with Claimant's 1996 injury. (EX 13-15).

The deposition of Dr. William Fleet, a board certified neurologist, was taken twice, and his medical records are Claimant's Exhibit 4. Dr. Fleet testified he first examined Claimant on January 29, 1998, and was informed of a fusion Claimant underwent 20 years previously, as well as an accident in May, 1996, for which Claimant underwent an anterior cervical discectomy and fusion at C3-4 and C6-7 in July, 1996. Although Claimant related initial relief of her pain following surgery, she testified the pain had resumed.

An MRI performed on February 7, 1998, revealed Claimant had cervical stenosis at C5-6 with neuroforaminal encroachment at numerous levels and marked cervical stenosis at C5-6. Based upon these studies, Dr. Fleet recommended Claimant undergo electromyelogram and nerve conduction tests of the arms and neck, as well as a cervical myelogram with a follow-up CT. Dr. Fleet additionally opined surgery, most likely a decompressive laminectomy at C5-6, may be necessary in Claimant's future for pain relief and prevention of a possible quadriplegic condition. (CX 4).

According to Claimant's Exhibit 5, Claimant was seen by Dr. Andre J. Fontana, a board certified orthopaedic surgeon, on July 30, 1998, following Dr. Fleet's surgical recommendation. After a long discussion with Claimant, Dr. Fontana recommended Claimant be referred to Dr. Robert White who would be able to perform the anticipated surgery. At the time of the visit, Claimant was complaining of severe neck pain with some radiating pain to the left shoulder and some numbness in her left hand.

On Dr. Fleet's final visit with Claimant, on December 10, 1998, his prognosis was that Claimant would continue to experience pain and probable further degenerative changes of her neck with time. At this point, without additional testing, Dr. Fleet was simply recommending pain management. (CX 4).

Dr. Fleet related Claimant's continued complaints, including neck pain radiating down her left arm, pain in both shoulders, headaches, subjective weakness in her left hand and some numbness in the fingers of the left hand, to her work related injury of May, 1996. Dr. Fleet stated Claimant was at maximum medical improvement at the time of his deposition only if Claimant was offered nothing further to improve her condition. Dr. Fleet opined the testing and treatment he recommended to be reasonable and necessary if Claimant's treatment was continued. Dr. Fleet stated it would not be advisable for Claimant to be working due to her severe cervical stenosis causing compression of her cervical spinal cord, her continued pain, and difficulty using her left arm.

Dr. Fleet, when questioned regarding the normal EMG study completed in January, 1998, testified that this did not change his opinion and explained that the MRI related impingement of the left arm and that the EMG could not rule out such impingement. Dr. Fleet opined Claimant should not lift more than twenty pounds

and would not consider her capable of sitting at a desk for a normal workday because of Claimant's complaints of pain. Dr. Fleet testified Claimant's ability to stand and walk is limited due to her accident. He additionally opined Claimant would be more likely to be able to return to work if the additional surgery he recommended was performed.

When confronted with Dr. Fleet's opinion in his deposition, Dr. Grabel disagreed with Dr. Fleet's recommendation of nerve conduction studies, describing them as useless, and found Dr. Fleet's recommendation for a myelogram questionable. Dr. Grabel acknowledged he has not examined Claimant since May 30, 1997, and testified that if Claimant was experiencing pain he would consider it reasonable for her to seek treatment from an available physician. Additionally, Dr. Grabel acknowledged Claimant was at an increased risk of developing bulging or herniation at other levels of her cervical spine following the various surgeries because the fused segments of Claimant's spine are immobile and therefore greater stress is placed on the nonfused adjacent segments.

Dr. Chahub was also questioned regarding the February 7, 1998, MRI results and Dr. Fleet's opinion provided at his deposition. Dr. Chalhub testified the MRI results were abnormal without Claimant experiencing a subsequent injury and did not change his previous position that Claimant could return to a sedentary work position with a twenty-five pound weight limit. Dr. Chalhub did not recommend further surgical intervention.

Correspondence regarding medical bills for services and prescriptions are contained in Claimant's Exhibits 1 and 12-15.

Other Evidence

Labor Market Surveys from Victor F. Steckler are Employer's Exhibits 18 and 19. Reports dated January 15, 1998, and February 8, 1998, identify a dozen jobs purported to meet Claimant's restrictions. Positions identified were administrative assistant/clerical, customer service/telemarketing, hostess, desk clerk, outpatient admissions clerk, admitting clerk, and dental assistant. Salaries ranged from minimum wage to $10.00 an hour.

Employer's Exhibit 41 contains Claimant's records regarding her contact with the potential employers identified in the Labor Market Survey. According to

Claimant's records, either the phone was disconnected or no positions were available at all listed employers except one. A part-time hostess position requiring seating customers and answering phones was available three nights a week and paid minimum wage. Employer's Exhibit 40 contains cover letters Claimant sent to various positions she applied for after discovering the ads in the newspaper.

Employer's First Report of Injury is Employer's Exhibit 34 and reveals Claimant first lost time from the accident on May 24, 1996, after injuring her neck while walking on base. Employer's Exhibit 38 is Claimant's LS-200 dated March 9, 1998. Employer's Exhibit 39 is an Employer's brochure for the Andros Ranges.

Employer's Exhibit 17 is Claimant's resume. Claimant's Exhibit 3 and Employer's Exhibit 35 is Claimant's Employment Agreement with Employer, dated August 19, 1995, indicating Claimant's employment was to begin on October 10, 1995, at the rate of $6.00 an hour plus a 15% Foreign Service Pay bonus. A Performance Assessment dated February 9, 1996, is Claimant's Exhibit 10 and reveals Claimant was rated to meet or exceed requirements in all areas. Claimant's work certifications are contained in Claimant's Exhibit 11 and include Claimant's certification for a driver's license, bulldozer, front end loader, and dump truck.

Claimant's 1995 and 1996 income tax returns are Claimant's Exhibit 2, and her W-2 forms from Employer for 1995 and 1996 are Employer's Exhibit 36 and 37. Claimant's application for a handicap parking application is Claimant's Exhibit 16 and the application sited Claimant's long term disability as her inability to walk long distances.

Findings of Law and Fact

Causation

Employer does not contest that Claimant suffered a job related accident on May 24, 1996, in which she suffered injuries to her back and neck. However, Employer argues Claimant's complaints of urticaria and throat symptoms are not related to her May, 1996, injury, and therefore Employer is not responsible for payment of the medical treatment.[3]

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[3] Claimant additionally complained of sleep disorder with diffuse arthralgias and myalgias, however, no issue has been presented regarding this complaint. Dr. Kemp was the only physician to address the etiology of the complaint and he specifically related them to Claimant's on-the-job

Section 20(a) of the Act provides Claimant with a presumption that her disabling condition is causally related to her employment if she shows that she suffered a harm and that employment conditions existed which could have caused, aggravated or accelerated the condition. Gencarelle v. General Dynamics Corp., 22 BRBS 170 (1989), aff'd, 892 F.2d 173, 23 BRBS 13 (CRT) (2d Cir. 1989). Once the claimant has invoked the presumption the burden shifts to the employer to rebut the presumption with substantial countervailing evidence. James v. Pate Stevedoring Co., 22 BRBS 271 (1989). If the presumption is rebutted, the administrative law judge must weigh all the evidence and render a decision supported by substantial evidence. Del Vecchio v. Bowers, 296 U.S. 280 (1935).

I find Claimant invoked her presumption that the additional symptoms she suffered were a direct result of the May, 1996, accident. First, Claimant did not suffer from hives or her throat symptoms until after her on-the-job injury or the surgery performed to treat the injury. Additionally, neither Dr. Kemp nor Dr. deShazo, Claimant's treating allergists, could identify any other underlying cause for Claimant's continual urticaria, and her throat complaints were related to her July, 1996, surgery by Dr. Muller, an ENT. Therefore, the presumption is invoked and the burden is on Employer to rebut the presumption with substantial countervailing evidence.

Employer offers no evidence to rebut the connection between Claimant's sudden and continuous outbreak of urticaria, other than a statement by Dr. Kemp in which he did not relate the urticaria to her on-the-job injury. Dr. Kemp's statement, however, was based upon only his first few examinations of Claimant and was made at a time when Dr. Kemp opined Claimant's urticaria was under control. A review of the records reveals, however, that Claimant continued to experience repeated outbreaks despite the medications and treatments by Dr. Kemp. Dr. Kemp then referred Claimant to Dr. deShazo in hope of obtaining a different approach, and Dr. deShazo could offer no explanation for Claimant's continued urticaria. Therefore, Dr. Kemp's initial assessment appears to have been made prematurely, and both Drs. Kemp and deShazo accepted the history provided to them that related the beginning of Claimant's symptoms to her injury.

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injury.

Likewise, the medical evidence of record does not rebut the relationship of Claimant's throat symptoms to her May, 1996, injury. Employer points to Dr. Kemp's opinion relating Claimant's throat symptoms to gastroesophagael reflux disease. However, after treatment based upon this diagnosis failed, Dr. Kemp referred Claimant to an ENT, Dr. Muller. While Dr. Muller did state that Claimant's complaints of feeling a stick in her throat had nothing to do with Claimant's May, 1996, accident, he did relate the throat symptoms to scar tissue caused by the anterior cervical discectomy approach undertaken during Claimant's July, 1996, surgery. Because that surgery was treatment for her May, 1996, injury, any resulting side effects of the surgery are also injury related.

Employer additionally relies upon Dr. Grabel's opinion that the throat condition was a result of a medical allergy. However, the medications provided to Claimant were prescribed to treat injuries sustained or treatments related to the May, 1996, injury, and therefore any adverse reaction to the medicine would also be compensable.

Based upon the foregoing, it is my finding Employer has failed to rebut the presumption with substantial evidence. However, even if Employer had met its burden, when weighed as a whole the evidence supports a finding that Claimant's urticaria and throat symptoms are related to Claimant's May, 1996, injury.

Maximum Medical Improvement

Claimant and Employer disagree as to whether Claimant has reached maximum medical improvement (MMI). While Claimant asserts she has not yet reached MMI based upon the opinion of Dr. Fleet, Employer, relying on Dr. Grabel's opinion, argues Claimant reached MMI no later than March, 1997. For the reasons that follow, I find Dr. Fleet's opinion most persuasive and find Claimant has yet to reach MMI.

The date of maximum medical improvement is defined as the date on which the employee has received the maximum benefit of medical treatment such that her condition will not improve. The date on which a claimant's condition has become permanent is primarily a medical determination. Manson v. Bender Welding & Mach. Co., 16 BRBS 307, 309 (1984). The date of maximum medical improvement is a question of fact based upon the medical evidence of record regardless of economic or vocational consideration. Louisiana Insurance Guaranty Assoc. v.

Abbott, 40 F.3d 122, 29 BRBS 22 (CRT) (5th Cir. 1994); Ballesteros v. Willamette Western Corp., 20 BRBS 184, 186 (1988); Williams v. General Dynamic Corp., 10 BRBS 915 (1979). However, if the medical evidence indicates that the treating physician anticipates further improvement, unless the improvement is remote or hypothetical, it is not reasonable for a judge to find that maximum medical improvement has been reached. Dixon v. John J. McMullen & Assoc., 19 BRBS 243, 245 (1986); See Mills v. Marine Repair Serv., 21 BRBS 115, 117 (1988). The mere possibility of surgery does not preclude a finding that a condition is permanent, especially when the employee's recovery or ability is unknown. Worthington v. Newport News Shipbuilding & Dry Dock Co., 18 BRBS 200, 202 (1986); White v. Exxon Co., 9 BRBS 138, 142 (1978), aff'd mem., 617 F.2d 292 (5th Cir. 1980).

Employer argues Claimant reached MMI on May 30, 1997, based upon the opinion of Dr. Grabel. Dr. Grabel first treated Claimant two months following her injury and continued treatment for another 10 months. Dr. Grabel noticed gradual improvement in Claimant's condition and by May of 1997, opined Claimant needed no further surgery or physical therapy. By October, 1997, Dr. Grabel approved of work restrictions identified in Claimant's FCE. However, a variety of indications lend credence to Claimant's argument that Dr. Grabel was overly optimistic regarding her recovery.

First, Claimant continued to require treatment for her urticaria and throat symptoms after May of 1997, and reported daily outbreaks of hives for months after that date. Claimant also testified that she was still experiencing debilitating back and neck pain as of May, 1997, and requested Dr. Grabel to refer her to a physician nearer her residence so she could continue treatment. Notably, Dr. Grabel did refer Claimant to another physician, Dr. White, although the referral was never authorized. He also explained in his deposition that continued treatment was reasonable if Claimant was still experiencing pain. From this referral one can certainly infer Dr. Grabel acknowledged further treatment was necessary in light of Claimant's continued pain.

Additionally, Claimant's credible testimony establishes that although she noted some initial improvement after the July, 1996, surgery, she does not feel she has yet recovered and neither does Dr. Fleet. Dr. Fleet was the most recent physician to examine Claimant, and he found her complaints credible and verified by the results of a recent MRI. Dr. Fleet explained that the normal nerve conduction

and EMG studies Dr. Grabel was relying upon could not rule out the impingement revealed on the MRI. Based upon the MRI and Claimant's complaints of pain, Dr. Fleet has recommended further testing in anticipation of surgery which he opined will improve Claimant's condition.

Finally, Employer also relies upon the opinion of Dr. Elias Chalhub who opined that at the time of his examination in January, 1998, Claimant could return to work with a twenty-five pound weight limit. However, I find Dr. Chalhub's opinion unpersuasive. After learning of Claimant's MRI results, Dr. Chalhub opined the results indicated a subsequent injury unrelated to her May, 1996, accident. No such event has been shown and both Drs. Fleet and Grabel acknowledge that the surgical fusions performed in May of 1996, could create instabilities in other areas of Claimant's spine. Additionally, Claimant described the independent medical examination performed by Dr. Chalhub as extremely brief.

Therefore, based upon the opinion of Claimant's most recent physician, Dr. Fleet, that additional treatment would improve Claimant's condition, and the recent MRI results which support his findings, I find Claimant has yet to reach maximum medical improvement.

Nature and Extent

In this case, both Claimant and Employer stipulated they are satisfied with the amount of disability compensation paid prior to March 6, 1998, except for 6 days of disability paid in October, 1996. Claimant, however, has not received any disability payments since March 6, 1998, and argues she was, as of March 6, 1998, and continues to be, totally disabled. Employer argues Claimant was able to work after March 6, 1998, and therefore should only be eligible for partial disability, if any. As for the week in October, Claimant feels she was underpaid while Employer believes it is due a credit of $189.26.

Having established an injury, the burden now rests with Claimant to prove the nature and extent of her disability. Trask v. Lockheed Shipbuilding Construction Co., 17 BRBS 56, 59 (1985). A claimant's disability is permanent in nature if she has any residual disability after reaching maximum medical improvement (MMI). Id. At 60. The question of extent of disability is an economic as well as medical concept. Quick v. Martin, 397 F.2d 644 (D.C. Cir. 1968); Eastern S.S. Lines v. Monahan, 110 F.2d 840 (1st Cir. 1940). A claimant who shows she is unable to return to his former employment establishes a prima

facie case for total disability. The burden then shifts to the employer to show the existence of suitable alternative employment. P & M Crane v. Hayes, 930 F.2d 424, 430 (5th Cir. 1991); N.O. (Gulfwide) Stevedores v. Turner, 661 F.2d 1031, 1038, 14 BRBS 1566 (5th Cir. 1981). Furthermore, a claimant who establishes an inability to return to her usual employment is entitled to an award of total disability compensation until the date on which the employer demonstrates the availability of suitable alternative employment. Rinaldi v. General Dynamics Corp., 25 BRBS 128 (1991).

Issues relating to nature and extent do not benefit from the Section 20 presumption. The burden is upon Claimant to demonstrate continuing disability (whether temporary or permanent) as a result of her accident. In this instance, I find Claimant was temporary partially disabled from October 21, 1996, to October 26, 1996, and as of March 6, 1998, Claimant was and continues to be temporary totally disabled.

Claimant has presented a prima facie case for total disability as she has shown she is unable to return to her previous employment based upon the opinions of Drs. Fleet, Grabel and Chalhub. None of the physicians opined Claimant could return to her previous duties of carrying a 30 pound shoulder bag. Therefore, the burden shifts to Employer to show suitable alternative employment.

As for the week in October, 1996, in which disability payments are questioned, Employer provided Claimant with suitable alternative employment in the form of light duty work. At the time of the offer, Dr. Grabel was of the opinion Claimant could return to work based upon the limitations of the FCE, which Employer apparently followed. Therefore, because Claimant was afforded the opportunity to work and did return to work, Claimant was only temporary partially disabled during this period. I find Claimant partially disabled because, according to her testimony, she was only paid $6.00 per hour and worked, at most, 24 hours during these 6 days, whereas, on the island she had earned $6.00 per hour plus a 15% foreign service bonus and worked 48 hours per week.

Regarding the period following March 6, 1998, Employer introduced labor market surveys which identified a dozen jobs in the area. However, only one Employer acknowledged having an available position when contacted by Claimant. There is contrary evidence in the record regarding whether or not this part-time hostess position would require the employee to carry food trays which would be difficult if not impossible for Claimant to perform with her current symptoms and

weight limits. However, regardless of the specifics of the hostess job, Claimant has proven she is unable to perform it or any other employment based upon the opinion of Dr. Fleet.

Dr. Fleet was the last physician of record to examine Claimant and based upon objective testing and Claimant's subjective complaints, Dr. Fleet opined Claimant is unable to return to any type of work at this time. While Dr. Grabel opined Claimant could return to work with the restrictions outlined in the functional capacity evaluation, even he testified he would prefer Claimant's FCE be performed by a physician rather than a rehabilitation counselor, as was done in Claimant's case, in light of the complexity of Claimant's condition. Dr. Chalhub, after one visit, also stated Claimant could return to work with a twenty-five pound weight limit based upon normal nerve conduction and EMG test results. However, neither Dr. Chalhub nor Dr. Grabel examined Claimant after the abnormal MRI results which Dr. Fleet based his opinion upon were obtained, and Claimant's credible testimony establishes her inability to do anything, even sit or stand for a few hours at a time. Therefore, based upon the opinion of Dr. Fleet and the credible testimony of Claimant, I find Claimant was temporary totally disabled as of March 6, 1998, and continues to be.

Choice of Physician

Claimant, in this case, argues she has yet to select a physician of her choosing and that she should have the right to do so and to be able to choose a physician in her area of residence. I find Claimant did select a physician of her choosing when she sought treatment with Dr. Fleet and that Employer is therefore responsible for payment of the treatment provided by Dr. Fleet.

Employer chose each of Claimant's physicians until Claimant returned home to the Mobile area and requested Dr. Grabel to refer her to a local physician, Dr. White. Although Dr. Grabel's testimony establishes he made the referral, Employer refused to authorize such a transfer, and Claimant then sought treatment with Dr. Fleet on her own, without first obtaining approval by Employer.

Although Employer is ordinarily not responsible for the payment of medical benefits if Claimant fails to obtain the required authorization, such failure can be excused where the Claimant has been effectively refused further medical treatment. Slattery Assoc. v. Lloyd, 725 F.2d 780, 787, 16 BRBS 44, 53 (CRT) (D.C. Cir. 1984); Swain v. Bath Iron Works Corp., 14 BRBS 657, 664 (1982); Washington v. Cooper Stevedoring Co., 3 BRBS 474 (1976), aff'd, 556 F.2d 268, 6 BRBS 324 (5th

Cir. 1977). Because Employer refused to authorize Dr. Grabel's referral of Claimant to a local physician, Claimant was effectively refused medical care and therefore is excused from failing to follow the appropriate procedure.

Having found Dr. Fleet to be Claimant's first choice of physician and Employer responsible for the payment of Claimant's medical treatments with Dr. Fleet, the only remaining issue is the reasonableness of Dr. Fleet's proposed treatment.

In order for a medical expense to be assessed against the employer, the expense must be both reasonable and necessary. Parnell v. Capitol Hill Masonry, 11 BRBS 532, 539 (1979). Medical care must be appropriate for the injury. 20 C.F.R. § 702.402. A claimant has established a prima facie case for compensable medical treatment where a qualified physician indicates treatment was necessary for a work related condition. Turner v. Chesapeake & Potomac Tel. Co., 16 BRBS 255, 257-258 (1984). The claimant must establish that the medical expenses are related to the compensable injury. Pardee v. Army & Air Force Exch. Serv., 13 BRBS 1130 (1981). Suppa v. Lehigh Valley R.R. Co., 13 BRBS 374 (1981). The employer is liable for all medical expenses which are the natural and unavoidable result of the work injury, and not due to an intervening cause. Atlantic Marine v. Bruce, 661 F.2d 898, 14 BRBS 63 (5th Cir. 1981), aff'g 12 BRBS 65 (1980).

I find the additional testing indicated by Dr. Fleet to be reasonable and necessary medical expenses. As noted previously, Dr. Fleet has treated Claimant for the past year and he has related the need for all of Claimant's treatments to her on-the-job injury sustained in May, 1996. There are no reports of intervening injuries in the record.

Dr. Fleet is a board certified neurosurgeon and his recommendations for additional testing and possible surgery are based upon Claimant's abnormal MRI results and her continued subjective complaints of pain. Although Employer argues that both Dr. Grabel and Dr. Chalhub did not indicate the need for further testing or surgery, Dr. Chalhub examined Claimant only once and Dr. Grabel has not examined Claimant in over a year. Additionally, in light of Claimant's constant and debilitating pain despite past treatment options, further testing and assessment appears a reasonable course.

In sum, I find Employer is responsible for all past and future medical expenses related to Claimant's injuries, including the medical expenses of Dr. Fleet

and those expenses related to treatment for Claimant's urticaria and throat symptoms, which were previously determined to be related to Claimant's May, 1996, on-the-job injury.

Travel Expenses

In addition to her medical expenses, Claimant also seeks reimbursement for travel expenses incurred while obtaining medical care. Because I have found Claimant's past treatments reasonable and work-related, Claimant is also entitled to reimbursement for reasonable travel related expenses. Tough v. General Dynamics Corporation, 22 BRBS 356 (1989); Gilliam v. The Western Union Telegraph Co., 8 BRBS 278 (1978).

Employer's Entitlement to 8(f) Relief

Because I find Claimant has not yet reached maximum medical improvement, 8(f) is not ripe for resolution at this time.

Conclusion

Based upon the foregoing findings of fact, conclusions of law and the entire record, I hereby enter the following order:

Order

It is hereby **ORDERED** that, in addition to the compensation previously paid, with which the parties are satisfied:

1. Employer shall pay to Claimant compensation for her temporary partial disability from October 21, 1996, to October 26, 1996, based upon the average weekly wage of $331.20, reduced by her residual wage earning capacity of $144.00[4] for the six day period[5];

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[4]Although the amount of disability paid during this week in October was listed as an issue to be resolved, neither party submitted evidence as to the actual hours worked by Claimant during this period other than Claimant's vague testimony. Claimant's testimony established that when she returned to work she could only do so for, at most, 4 hours a day. Therefore, the residual wage earning capacity was computed by taking the 24 hours Claimant testified she worked (4 hours a day for 6 days) and multiplying by the amount Employer paid Claimant according to the

2. Employer shall pay to Claimant compensation for her temporary total disability from March 6, 1998 (date of last disability payment), and continuing, based upon the average weekly wage of $331.20 with a corresponding compensation rate of $220.80.

3. Pursuant to Section 7 of the Act, Employer shall be responsible for Claimant's reasonable and necessary medical and travel expenses, including all past and future expenses of Dr. Fleet and expenses related to treatment for Claimant's urticaria and throat symptoms;

4. Employer shall pay interest on all of the above sums determined to be in arrears as of the date of service of this ORDER at the rate provided by in 28 U.S.C. §1961 and Grant v. Portland Stevedoring Co., 16 BRBS 267 (1984);

5. Counsel for Claimant, within 20 days of receipt of this ORDER, shall submit a fully supported fee application, a copy of which must be sent to opposing counsel who shall then have 10 days to respond with objections thereto. See, 20 C.F.R. §702.132; and;

6. All computations of benefits and other calculations which may be provided for in this ORDER are subject to verification and adjustment by the District Director.

Entered this 29th day of March, 1999, at Metairie, Louisiana.

C. RICHARD AVERY

testimony which was $6.00 an hour and did not include the 15% foreign service pay.

[5] Employer shall receive a credit for any disability benefits paid to Claimant under the Act from October 21, 1996, to October 26, 1996.

CRA:ac Administrative Law Judge